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OVERCOMING BARRIERS TO EFFECTIVE EVALUATION OF EDUCATION IN PUBLIC HEALTH PROGRAMS

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My task in leading off this opening session of the institute * is to provide a starting point for discussion of the problem of overcoming barriers to effective evaluation of health education.

The normal orientation for a discussion of barriers is to frame the problem in terms of roadblocks which lie out there ahead of us—obstacles in our onward, upward path. In this way of sizing up the situation, we cast ourselves in the role of barrier-overcomer. This is probably a pretty comfortable role for there is frequently as much credit accruing for the courage and steadfastness with which the barrier is attached as that which comes for actually overcoming it.

If you continue to think about the topic though, you may find that there is another way to see our relationship to barriers. A barrier may also be used, indeed especially constructed, as a place behind which one can crouch for protection or from the ramparts of which home, hearth, and ego are protected.

And so—which do we talk about as we dig into the problems of evaluation and the barriers to it? This is a critically important question, for we cannot hope to discuss the topic productively unless we stop to ask which side of the barrier we are concerned with at any particular time.

A Look At Evaluation

Now for a look at another word in the title: evaluation.

In the few weeks which have elapsed since I was invited to participate in the institute, I kept track for a while of the times I heard "evaluation" used. I gave up very soon; the list became too long. I heard the word in connection with problems, situations, and people. Among many other topics, I listed baseball teams, heart conditions, ideas, atomic bombs—all being "evaluated." If I add as well the times in which other words were used with exactly the same meaning, the list would grow to Himalayan proportions. Evaluation is certainly a frequently used term and serves in most cases to cover in a very broad way many forms of judgment. Although we cannot close our eyes to these meanings involved in the general use of the word "evaluation," certain it is that we will have to be more precise in our use of it here. I think we can agree that for the purposes of program development, "evaluation" must be used to signify the whole process through which we assess progress toward goals. If we are to make meaningful assessments or judgments about our progress, then we know, too, that we need to have good descriptive data which will indicate where we were when we started, where we were headed, what happened to us on the way, and where we are now.

If we do accept this point of view, that we are concerned here with the process of assessing progress toward goals, then it is equally important to realize that the mere collection of data—be they qualitative or quantitative, statistically complex or simple, objective or subjective, good or bad—is *not* in itself evaluation. The essence of evaluation is the *application of value judgment* which grows out of carefully gathered evidence. This job—this business of applying the judgment—is the job of the practitioners who have created and developed the program, just as much as the related phases of planning and execution were theirs. Not all the expert data-collectors, not all the fancy instruments, not all the theory experts we can bring together can do this job for us. To delegate the evaluation function is to delegate away our best hope for putting evaluation to work.

One more point about evaluation. *It is not research.* The two operations have been so frequently voiced in the same breath that they seem to have taken on a kind of Siamese-twin existence. Program evaluation relating to health education is not designed to prove that education is possible *nor* necessarily to create new methods or theories. Program evaluation relates to our goals, our progress, our situation, our own needs and purposes. What we want to do is be able to form a judgment based on facts which are as descriptive as the situation permits: How are we doing? How can we be doing better? We have these questions with us always.

Carefully planned evaluations can contribute to a research effort and often do. They can provide the basis for putting forth or testing hypotheses, and they often do. But, if we forget who we are and what we are about, we may find ourselves far afield and perhaps isolated from the events

* This paper was given at the Institute for Health Educators at Asilomar, October 17-20, 1961. Other papers given there will appear in later issues.

for which we as practitioners have accepted a central role.

Organizational Structure

This leads to the next point, which has to do with the settings within which we operate and the limitations imposed by the structure and function of our organizations.

Health education as a professional field was rough hewn out of the needs of public health. It developed not out of the logical requirements of an academic discipline, but out of the needs peculiar to public health organization and administration.

Among a great many other things which this means is that the nature of the bureaucratic setting is a factor of more than academic importance.

Merton [1] has classified for us some things which will certainly be familiar. He lists a bureaucratic structure as involving:

1. Clearly defined pattern of activity relating to the purposes of the organization.
2. Integrated series of offices—a hierarchy of status in which there are numbers of obligations and privileges clearly defined.
3. Official action ordinarily occurring within the framework of pre-existing rules.

One is not in a bureaucracy long before he knows, too, that objectives are neither simply determined nor consistently adhered to; that judgments of an action are more often than not based on usefulness to the organization rather than toward achievement of an abstract goal; that data and value judgments which come under the general scope of evaluation broadly defined are used most frequently, to put it in its most positive sense, for one level of the heirarchy to interpret its importance and the necessity for its existence to the next higher level. Thus, every element in the chain is intent on finding data to:

1. Support its claim to competence in the areas it considers important.
2. Defend its integrity.

The demands of such situations often mean that evaluation is seen as too crucial an operation to be left within the usual structure of program planning and implementation and must be turned over instead to the outside expert, the outside auditor.

Just in case some of you, caught up in this potpourri of complex relationships which is a modern bureaucracy, feel that no one understands you, may I quote this bit from Max Weber:

> "In a great majority of cases he (the bureaucrat) is only a single cog in an ever-moving mechanism which prescribes to him an essentially fixed route of march. The official is entrusted with specialized tasks and normally the mechanism cannot be put into motion or arrested by him, but only from the very top. The individual bureaucrat is thus forged to the community of all the functionaries who are integrated into the mechanism." [2]

And so we have it—this setting in which we work: highly organized, extremely patterned, with roles presumably set by regulation, with every level attempting to sit in judgment on every other level, and with the whole mechanism straining to keep itself going by providing to the appropriate authorities the kind of interpretation which will gain most favor.

The question of evaluation, then, is bound to raise counterquestions: Evaluation of whom—for what purpose—on whose authority? "Evaluation" can pose a threat of the highest order. It comes back again and again to threaten us.

Even if we should escape this snarl, we usually end up by being at a place in the hierarchy from which "evaluation" does not usually originate and find ourselves deterred in the task of evaluation before we begin.

These are important barriers. There is not much sense in denying their existence, and I am not quite sure that they can always be overcome as we would wish them to be. But the job of a health educator, as Nyswander [3] said in a somewhat different but related context, is, in some cases, to open the eyes of those involved in a problem to the existence of barriers and their subsequent exploration; and, in other cases, to help those who would stop too short to see "that a limitation is not a barrier until a dozen ways have been explored."

One way (I am not sure of the other 11) to explore this particular barrier is to view evaluation as an educational process involving the same principles, the same approaches, as other activities concerned with helping people to learn.

On the premise that responsibility for educational activity is diffused throughout a department, then responsibility for evaluation is also diffused. And, if the planning for a department's educational activity is best accomplished through participation of those involved, then planning for evaluation must likewise include those who have a contribution to these activities or whose work is likely to be the subject of judgments.

As health educators, we can perhaps accomplish more for the overall "accomplishment-recording" aspects of evaluation by concentrating on the processes through which we make the "evaluation of educational programs and methods by staff provide a supporting structure for introducing changes in context and methods." [4] This last quotation from Nyswander emphasizes that we should not be concerned only with the health educator's "doing" evaluation—any more than we are concerned only with our "doing" educational activity—but should use evaluation to produce conditions which will provide for effective program development and for the learning and changing which must go on in a staff to bring this about.

If we can see evaluation in this way, then we may see with greater clarity what Parker [5] had in mind when he said that the most important aspect of a successful evaluation effort is to make the application of value judgment a joint enterprise of all those concerned.

It is, I think, only in this way that we can stand clear of the danger posed by making ourselves an outside auditor of the actions of others or find ourselves in a bureaucratic blind alley of attempting to initiate activities which we have neither responsibility to assume nor authority to execute.

Education More Than Behavior Change

Now a new point—one which may not be so much a barrier to evaluation as a barrier which can be created by evaluation which is too narrowly construed.

We all know that our emphasis, for good and sufficient reason, has been on getting those who must have some responsibility for health education to come to grasp with the problem of defining specific behavior changes to be sought. This has helped us move away from general, vague, meaningless

ends, and it has focused education where it belongs—on behavior . . . But, in so doing, we may have, or so it seems to me, fallen for our own oversimplification. I hear much talk of behavior change, but I am getting the uneasy feeling that education and behavior change have too frequently become synonymous terms. I have a feeling that we have forgotten that there are indeed many ways to bring about change, only *some* of which can be classified as educational.

I don't for a moment insist that only "educational" methods be used by an agency, nor do I hold any notion that everything a health educator does is educational, but I do think —and strongly so—that our evaluation of education must take into account an analysis of the reasons for change and the means which have been used in bringing it about. We cannot evaluate "education" by focusing only on narrowly defined behavioral outcomes as criteria of success. By so doing we run the risk of using data which are irrelevant or even inimical to the process which we ostensibly set out to evaluate.

A Positive Note

I want to move quickly to a more positive note: a kind of Magna Carta for the overcoming of barriers.

What we need and need desperately, if we are serious, is to work out a mechanism for getting the stuff to do the job of evaluation day in and day out. Nobody is going to do it for us. No other discipline is likely to solve our problems. We can get plenty of help—particularly from social scientists and others who have become associated more directly with public health work, but they are no more able, or even interested, in providing us with the tools for evaluation that we need for our *practice* than we are able, or even interested, in providing tools for *their* practice. We need some simple (and simple is not equivalent to easy or gotten without hard work) instruments to gather the kind of data we continually need. We need models of ongoing efforts covering the whole scope of planning and evaluation. We need to work on the possibility of developing, for the different levels and dimensions of our evaluation processes, sets of indicators which may help to give us clues as to how we are doing while we are still on the way, and while we still have a chance to speed up or take the correct turn. These things we, as a profession—as a group of practicing health educators—can do. How wonderful it would be if we could stimulate, for example, the design and implementation of a cooperative study of educational evaluation in public health within the framework of which we would join together in a long-range effort to provide the help we all need.

The Energy of Curiosity

We know that throughout all our experiences we are constantly engaged in a "search for meaning." We try always to have things make sense, to "fit in."

As Brameld [6] has said: "most men do not want bewilderment; they cherish the values of fairly immediate meaning, significance, order, direction." Whether it is formal or informal, rational or irrational, sound or unsound, the attempt to provide ourselves with meaning goes on. And this tendency, shared by all of us, can furnish our most important source of strength as we go about the task of trying to decide how well we have done.

We can, if we will, harness this energy of curiosity, of the search for meaning. We can harness it to objectivity and shared experience and use it as a starting point for getting at the twin purposes of evaluation: sound judgments and individual growth in ability to make judgments. . . . And we can contribute in full measure to the strength of our profession and more importantly to the dignity of our society.

Faith, Hope, and Charity

When I was first asked to talk on evaluation, it was suggested that perhaps a word of "hope" was in order. Let me then close with reference to that attribute and its sisters as well—for I think that as we approach the problems of evaluation, we will need to do so with a *faith* that our techniques are suitable, *hope* that funds will be forthcoming, and considerable *charity* toward those who choose to get themselves involved in what can be so thankless a task.

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C. F. Blankenship, M.D., Retires From Public Health Service

C. Fred Blankenship, M.D., Regional Health Director of Region IX, Public Health Service, retired November 30 after 26 years in the service. He came to the San Francisco office in 1956 and has been regional director ever since.

Dr. Blankenship has accepted a position as Acting Head and Professor of Community Health in the School of Medicine, University of Louisville, Louisville, Kentucky.

R. Leslie Smith, M.D., will be Acting Regional Health Director of Region IX until a permanent replacement is found for Dr. Blankenship.

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Dr. Merrill Elected President Of State Health Officers Group

Malcolm H. Merrill, M.D., California State Director of Public Health, was elected president of the Association of State and Territorial Health Officers at the annual meeting of the association in Detroit in November. Dr. Merrill has been a member of the association's executive committee since 1956.

At this meeting the health officers drew up a list of almost a hundred public health activities that they feel need increased attention. The list with the association's recommendations was submitted to the Surgeon General and the Chief of the Children's Bureau.

Among the recommendations were these:

That the primary responsibility for health and safety in relation to *radiation hazards* be vested in the Public Health Service and in the state health departments.

That the Department of Health, Education, and Welfare be designated as the national agency responsible for the *civilian health defense mobilization program.*

That uniform *radiation protection standards* be developed at all levels of government and that more federal aid be provided for surveillance and control of radiation hazards at the state level.

That there be a national *census every 5 years* instead of every 10 years.

That state and local public health agencies be authorized to accept fees for *home care services* to the ill and disabled.

That support be forthcoming for the fifth International *Conference on Health and Health Education,* which meets in Philadelphia in July 1962.

That state and local health departments encourage *metropolitan planning of health services* and report developments in that field to the Public Health Service for collating and distributing to interested groups.

That *planning for co-ordination of hospitals* and other medical care facilities in metropolitan areas be stimulated by providing federal aid to local planning bodies.

That *air pollution control programs* be strengthened and include more federal aid to states and communities.

That the Public Health Service design *sanitation programs for harbors, ports, recreational and inland waters,* which state and local sanitation agencies can carry out.

That a program be designed to regulate the *sanitation of buses, bus depots, and bus servicing facilities.*

That requirements be tightened for reporting names of persons with active cases of *venereal disease.*

That studies of *oral polio vaccination programs* be made for use in future community programs for control of other infectious diseases.

That there be a full-time physician in charge of state health department chronic disease programs; and more assistance be given to communities to increase services to the *chronically ill and aged.*

That pending federal legislation (S. 1130) which would authorize federal grants for *migrant health services* be passed.

That an increase of $5 million a year be made in funds for *Indian health programs.*

Other recommendations approved by the association dealt with child health programs, food sanitation, food and drug administration inspection services, modernization of hospitals, support of the Milk Sanitation Act, public swimming pool sanitation, stepped-up programs for detecting visual defects, accident prevention, improvement of diagnostic laboratory services, need for more research programs in health departments and programs for training health personnel.

Special Grants Awarded for Radiological Health Training

Special training grants were awarded to members of local health department staffs for a course in monitoring and inspecting radiation sources in California. Staff members from the health departments in Los Angeles and San Bernardino Counties and the Cities of Long Beach and Pasadena attended a 10-week course presented by the University of California Engineering and Sciences Extension at the Berkeley campus.

The State Department of Public Health plans to delegate some monitoring and inspection duties to local health departments, and by law, trained staff must be available before these activities can be relinquished.

Robert Dyar, M.D., Member of Scientific Delegation to Russia

Robert Dyar, M.D., Chief, Division of Research, California State Department of Public Health, is one of a six-member scientific delegation currently visiting in Russia. Another Californian, Philip Lee, Jr., M.D., Palo Alto Medical Clinic, is also a member of the delegation. The men have been in Russia about a month visiting a number of medical institutes and health centers in the Soviet Union. They will return to the United States before the first of the year.

The visit is one of five official missions developed under terms of a 1960 agreement between the United States and the Soviet Union for co-operative exchanges in scientific, technical, education, and cultural fields.

Purpose of this exchange mission is to learn about health studies and services under way in different population groups within the Soviet Union. The delegation is studying cardiovascular and noninfectious disease problems in particular. The studies are expected to be of importance in the relatively new and growing field of medical ecology, which involves study of the interrelationship of the environment to the health and disease problems of people as individuals and as members of groups and communities.

New Position in MCH

For the first time in its history the Bureau of Maternal and Child Health of the State Department of Public Health has an assistant chief. David Kleinman transferred from the Bureau of Personnel and Training, where he has been assistant personnel officer since 1937, to assume the new position. Leslie Corsa, Jr., M.D., is Chief of the Bureau of Maternal and Child Health.

CALENDAR

January 27—Annual Margaret Beattie Lecture, San Francisco

February 16—Northern California Public Health Association Meeting, Richmond

March 22-24—American Orthopsychiatric Association Meeting, Los Angeles

May 4—Northern California Public Health Association, Annual Meeting, Berkeley

New Funds Available to Extend Services to Chronically Ill

The Community Health Services and Facilities Act of 1961 (Public Law 87-395), which became effective October 5, 1961, makes new funds available for the development and extension of out-of-hospital health services, particularly for the chronically ill and aged. One part of the act authorizes the Surgeon General to make project grants directly to public or nonprofit private agencies or organizations throughout the country; the other part provides grant-in-aid funds directly to states for distribution to agencies and organizations within each state.

Project Grants

Approximately two and a half million dollars is available nationwide for project grants to support studies, experiments, and demonstrations that will lead to new or improved community health services outside the hospital, with particular emphasis on services needed by the chronically ill or aged.

Application forms for these grants are available from C. F. Blankenship, M.D., Regional Health Director, Region IX, Public Health Service, Federal Office Building, San Francisco, California; or from Malcolm H. Merrill, M.D., State Director of Public Health, 2151 Berkeley Way, Berkeley, California.

Completed applications are to be sent directly to the Public Health Service, Washington 25, D.C. Staff of the State Department of Public Health will review applications prior to their transmittal to Washington, if requested.

Applications for project grants may be made at any time. Grants are for one to three years and any state or local public agency or nonprofit private agency or organization may apply. Grant funds may be used for direct costs, such as salaries and travel expenses, and the purchase of equipment, supplies, and services.

Projects should be designed to develop or demonstrate new or better ways of delivering health services, particularly to the chronically ill or aged. The hope is that many new, improved, and more economical methods of organizing and delivering out-of-hospital services will emerge from this program.

Grant-in-Aid Funds

From grant-in-aid funds received by the California State Department of Public Health, $288,300 will initially be allotted, in proportion to the state public health subsidy, to full-time local health departments or to other official or voluntary agencies designated by the local health officer. The designated amount will be held until January 6, 1962. Funds not applied for by this date will be available for support of supplemental services in a local health department or agency designated by the health officer.

To obtain an allotment, a plan for use of the money must be submitted to the State Department of Public Health by the first week in January. The plan will be reviewed by an advisory committee composed of the executive committee of the California Conference of Local Health Officers plus other qualified consultants. The committee will recommend approval, disapproval, or modification to the State Director of Public Health. All plans must have the acceptance of local governing bodies before funds can be finally paid. Grants are only for the 1961-1962 fiscal year.

To obtain funds in subsequent years it will be necessary to submit justifications for continuation of the 1961-1962 program extension, or for a new activity.

The money may be used to develop new, or to expand existing, services such as nursing care of the sick at home, homemaker services, co-ordinated home care programs, information and referral services in regard to facilities and services available for persons with long-term illnesses, screening clinics, nursing homes, and education and training of professional and nonprofessional personnel concerned with services for the aged or chronically ill.

The money may not be used for salary increases for existing staff; it may be used only to initiate, extend, or improve health services for the groups indicated. The funds may not be used to pay for an activity which pertains entirely to a single chronic disease for which there is another federal grant authorized, such as cancer, heart, or mental illness; they may, however, be used to support services affecting multiple diseases, or generalized activities for the chronically ill or aged.

Statewide Program Under Way for Accreditation of Nursing Homes

A statewide accreditation program for nursing homes, convalescent hospitals, boarding homes, rest homes, and sanitariums is now in operation by the new California Commission for the Accreditation of Nursing Homes and Related Facilities. This commission is composed of representatives of the California Medical Association; the California Hospital Association; the California Dental Association; the Southern California State Dental Association; and the California Association of Nursing Homes, Sanitariums, Rest Homes and Homes for the Aged, Inc.

It is the outgrowth of two years of work by the California Joint Council to Improve the Health Care of the Aged. Uniform standards for accreditation which the commission is using were developed by the council and will be revised as frequently as seems necessary.

The commission is not a state agency and its program will be carried out on a voluntary basis similar to that offered to hospitals by the Joint Commission on Accreditation of Hospitals at the national level.

Purpose of the program is to assist the owners and operators of some 4,000 nursing homes and related facilities throughout the State to raise the level of care which they offer and to recognize and give credit to those facilities in which operations are better than average or superior.

Wilson Sowder, M.D., Appointed Chief of PHS Office on Aging

Wilson T. Sowder, M.D., longtime director of the Florida State Health Department, has been appointed Chief of the Public Health Service's new Office on Aging.

The Office on Aging, to be located under the Chief of the Bureau of State Services, will develop policies, give consultation and guidance, and help in the existing efforts of the Service in the broad field of health of the aging. The new office will also coordinate the activities of the bureau toward a more effective application by state and local health departments of the research findings of the National Institutes of Health on diseases affecting the older-age population.

Blood Disorder Caused By Soap Ingredient

In response to a request from the University of California at Los Angeles, the Bureau of Occupational Health, State Department of Public Health, recently undertook an investigation of a blood disorder, methemoglobinemia, which occurred in certain patients at the Pacific State Hospital in Pomona.

This disorder results when the ordinary hemoglobin in the blood is converted to oxidized hemoglobin, a compound which has lost much of its oxygen transport capacity. At Pacific State Hospital nine patients suddenly developed a marked dusky, bluish discoloration of the skin characteristic of this disease.

The ward physician promptly diagnosed the condition and administered appropriate treatment to which the patients responded. Hospital authorities immediately investigated and considered the various possible causative factors. A careful examination, however, revealed no evidence of toxic materials known to produce this or related disorders.

The services of the Bureau of Occupational Health personnel were requested because of their familiarity with toxicological problems of an obscure nature. In collaboration with the hospital authorities, the epidemiologic aspects of the cases were traced through the 24-hour period immediately preceding the onset of the illness.

It became evident that the only change in technique was in the preparation of the soap gel used in the enemas. Differing from the usual procedure, the soap chips used to prepare the gel had been heated with a small quantity of water to a temperature near boiling for a period of one or more hours on the night preceding the incident.

The composition of the soap was obtained from the manufacturer, and it was learned that this particular product contained 2 percent by weight of a bacteriostatic agent which might conceivably break down to form a substance responsible for the outbreak of the disorder.

Laboratory tests on a sample of the soap proved conclusively that this was indeed the case and that heating the soap altered the chemical nature of the bacteriostatic agent. These breakdown products were then absorbed from the enema solution through the bowel wall to produce the oxidized hemoglobin and cyanosis characteristic of this disorder.

About 54 percent of persons in families having an annual income of $7,000 or more visited the dentist within the past year as compared with 19 percent of those families having an income of less than $2,000.—*Dental Care, Interval and Frequency of visits, U.S. July 1957–June 1959* PHS Publication No. 584-B15.

Personals

Helen E. Walsh, Chief, Bureau of Public Health Nutrition, State Department of Public Health, was elected president-elect of the Association of State and Territorial Directors of Nutrition at the annual meeting of the association in Detroit in November.

Harold M. Erickson, M.D., Deputy Director, State Department of Public Health, is the new president of the American Association of Public Health Physicians.

REPORTED CASES OF SELECTED NOTIFIABLE DISEASES CALIFORNIA, MONTH OF OCTOBER, 1961

Disease	*Cases reported this month*			*Total cases reported to date*		
Series A. By Place of Report	*1961*	*1960*	*1959*	*1961*	*1960*	*1959*
Amebiasis	38	29	39	458	387	526
Coccidioidomycosis	8	40	47	140	212	241
Measles	373	274	494	37,523	21,465	39,751
Meningococcal infections	18	12	9	184	169	168
Mumps	754	1,377	943	20,727	20,800	10,883
Pertussis	182	188	170	1,718	1,655	2,153
Rheumatic fever	5	8	9	93	122	122
Salmonellosis	123	120	102	1,176	1,067	976
Shigellosis	265	224	228	1,873	1,740	1,735
Streptococcal infections, respiratory	1,747	2,150	2,738	30,452	25,494	19,477
Trachoma	3	2	--	21	93	23
Series B: By Place of Residence						
Chancroid	6	5	10	86	98	67
Conjunctivitis, acute newborn	--	--	2	9	12	7
Gonococcal infections	1,940	1,727	1,340	19,072	15,731	14,138
Granuloma inguinale	--	--	1	4	10	2
Lymphogranuloma venereum	2	--	--	10	24	15
Syphilis, total	695	635	465	6,319	6,531	5,671
Primary and secondary	157	128	68	1,277	1,294	870
Series C: By Place of Contraction						
Botulism	--	--	--	--	--	2
Brucellosis	3	1	3	20	17	13
Diarrhea of the newborn	7	--	1	38	6	55
Diphtheria	--	--	1	2	--	6
Encephalitis	23	31	53	353	450	356
Food poisoning (exclude botulism)	70	167	77	2,192	1,421	1,345
Hepatitis, infectious	424	463	218	5,240	3,875	2,154
Hepatitis, serum	12	11	13	178	108	79
Leprosy	3	--	1	12	7	15
Leptospirosis	--	1	--	5	2	3
Malaria	2	--	1	9	11	24
Meningitis, viral or aseptic	100	69	79	678	608	747
Plague	--	--	--	--	--	2
Poliomyelitis, total	16	37	69	92	391	392
Paralytic	13	35	60	77	344	333
Nonparalytic	3	2	9	15	47	59
Psittacosis	--	2	--	9	13	14
Q fever	2	--	6	28	30	59
Rabies, animal	22	5	12	193	102	112
Rabies, human	--	--	--	1	--	1
Relapsing fever (tick borne)	--	--	--	5	6	3
Rocky mountain spotted fever	--	--	--	1	2	3
Tetanus	1	2	6	23	28	38
Trichinosis	--	--	2	12	3	7
Tularemia	--	--	--	4	3	4
Typhoid fever	9	11	9	58	53	67
Typhus fever (endemic)	1	--	--	4	--	3
Other *						
Tuberculosis [1]	--	--	--	3,854	4,285	4,388

* This space will be used for any of the following rare diseases if reported: Anthrax, Cholera, Dengue, Relapsing Fever (louse borne), Smallpox, Typhus Fever (epidemic), Yellow Fever.

[1] Tuberculosis cases are corrected to exclude out of State residents and changes in diagnosis; monthly figures are not published.

"Dial-A-Dietitian" Service Operating in California

"Does frozen orange juice have less nutritive value than fresh?" "Does toast have fewer calories than bread?" "Is it safe to store opened cans in the refrigerator?"

These and many other questions about normal nutrition are being answered by Bay area dietitians and nutritionists participating in a new "Dial-A-Dietitian" program. The service is offered by the Bay Area Dietetic Association in co-operation with the American Dietetic Association and the Nutrition Foundation, Inc.

Anyone in the Bay area may have questions about normal nutrition answered by dialing UN derhill 1-0479 from 10 a.m. to 5 p.m., Monday through Friday. The questions are referred to one of over 150 local dietitians and nutritionists who are volunteering their time to participate in the program. Information is given in regard to food values, food preparation, food sanitation, food buying, fads and fallacies relating to nutrition, feeding various age groups, food additives, and legal standards for food composition.

Questions are recorded on forms in duplicate by the telephone operator at the designated answering service, with the caller's name, address, and telephone number. One copy is mailed to the dietitian assigned for the day, who then telephones answers to the person asking the questions. On this copy, the dietitian records a resume of the answers given and forwards it to the chairman of the program committee. The chairman checks this copy with its completed information against the copy forwarded by the answering service.

During the first month of this service, 182 calls were received; as many as six questions have been asked in a single call.

The program is being financed by the Nutrition Foundation, Inc. and so far has cost around $50 a month to operate. A similar program is being initiated in the San Gabriel Valley in Southern California.

California's "Dial-A-Dietitian" programs are not the first in the country. A similar service has been provided in Detroit for over a year.

National Dental Health Center Established in San Francisco

A new national Dental Health Center, operated by the Division of Dental Public Health and Resources of the Public Health Service, has been established in San Francisco. George Nevitt, D.D.S., directs the center and its training activities, and John Greene, D.D.S., is head of the epidemiology program. Malcolm H. Merrill, M.D., State Director of Public Health, has accepted an appointment to the advisory committee to the center.

The Dental Health Center will conduct programs in applied research in the prevention and control of dental diseases and will train public health workers in the application of research findings. It is hoped that this approach will significantly reduce the time lag between the discovery of new knowledge and technics and their subsequent use in dental health programs.

The center was dedicated in November but has been in operation since July, and the staff of 20 is well under way on a variety of projects important to dentistry. At the present time there are three major programs in operation: dental public health training activities, dental education research, and the epidemiology of dental diseases.

The training program will fill a long existing need in the training of public health dentists and will complement other educational programs in this field. Areas that are receiving specific attention include a career development program for foreign dentists, short courses for professional and lay groups, consultative services for dental public health officials, a one-year residency program in dental public health, and a three-month field training program for public health dentists who are candidates for the MPH degree.

A primary concern of the education research program is an evaluation of teaching methods and aids to achieve optimal teaching and learning in dental education. Initial approaches include experimental studies with television and teaching machines.

Some areas which will receive primary attention from the epidemiology program will be the factors associated with the occurrence of cleft lip and palate, malocclusion, dental caries, and the epidemiology of periodontal disease.

As the Dental Health Center continues to grow, a program of applied research dealing with many phases of dental health will be conducted. It is expected that a close working relationship will be developed with state and local health departments, schools of public health, universities, medical and dental schools, and hospitals.

The center occupies a building on the grounds of the Public Health Service Hospital adjacent to the Presidio in San Francisco. The address is 14th Avenue and Lake Street, San Francisco 18, California.

Ruth Steinkamp, M.D., Joins Department Staff

Ruth Steinkamp, M.D., joined the staff of the Bureau of Public Health Nutrition, California State Department of Public Health, on December 1, 1961. Dr. Steinkamp has been serving as a consultant to the department for the past year. She will provide consultation within the department and to local health officers on the medical aspects of public health nutrition and will conduct specialized studies in the field of human nutrition.

Dr. Steinkamp received her B. S. and M. S. in nutrition at the University of Texas and took her dietetic internship at Johns Hopkins Hospital, Baltimore. After she obtained her medical degree at the University of Arkansas, she completed an internship, residency, and a fellowship in hematology at Barnes Hospital, St. Louis, Mo., which is associated with Washington University.

Dr. Steinkamp then went into private practice in St. Louis and during that time served as hematology consultant for Missouri Baptist and St. Louis County Hospitals. Her most recent position was that of hematologist with the Donner Laboratory, University of California, Berkeley.

She has also served as a consultant to a World Health Organization study group on iron deficiency anemias.

One of Dr. Steinkamp's first projects with the State Department of Public Health will be to conduct an obesity study based upon information obtained during a pilot study carried out this summer in which a number of department staff participated.

Public Health Positions

Alameda County

Public Health Nurses: Salary range $481-$584. Generalized program. Bachelor's degree and California Public Health Nurse Certificate required. Direct inquiries to: Miss Gertrude L. Anderson, Alameda County Health Department, Southern District, 15000 Foothill Boulevard, San Leandro, California.

Contra Costa County

Public Health Engineer: Salary range, $862-$1,047. Will be responsible for planning and directing the environmental sanitation programs of the health department. Minimum standards include graduation from a recognized university with a degree in engineering; possession of a valid certificate of registration as a professional engineer issued by the California State Board of Registration for Civil and Professional Engineers; plus five years of progressively responsible experience in engineering, three of which must have been in public health or sanitary engineering. One year of graduate study with a major in sanitary engineering, sanitary science, or public health may be substituted for one year of the required public health or sanitary engineering experience. Applications available from Contra Costa County Civil Service Department, P.O. Box 710, Martinez, California. Final date for filing is December 29, 1961.

Humboldt-Del Norte County

Health Officer: Salary range, $12,000 to $14,400 a year. Starting salary depends upon experience. Apply to Board of Supervisors, Humboldt County Court House, Eureka, California.

Los Angeles City

Public Health Microbiologist: Salary range, $464-$575. Must have a valid California Public Health Microbiologist Certificate or be qualified to take the state examination leading to such certificate. Apply Los Angeles City Hall, Room 5, Los Angeles 12, California. Telephone MAdison 4-5211, ext. 2442.

Yolo County

Microbiologist: Salary range, $553 to $673; advance to second step after six months. Laboratory staff consists of one microbiologist and a trained laboratory assistant.

Public Health Nursing Supervisor: Salary range, $527 to $641; advance to second step after six months. Master's degree in public health nursing supervision and/or administration is required.

Public Health Nurses: Salary range, $433 to $527; advance to second step after six months. Public Health Nursing Certificate required. Private car needed; car allowance 8¢ per mile.

For more information about any of these positions, write to Herbert Bauer, M.D., Yolo County Health Officer, Woodland, California.

History of Mental Health Movement in U.S. Now Available

Mental Health in the United States —A Fifty Year History, by Nina Ridenour, Ph.D., was published this year for the Commonwealth Fund by Harvard University Press. Although addressed to those who already know something about the subject—boards, staff, and volunteers of mental health associations; students of the medical, social and behavioral sciences; and professional workers in mental health and related fields—Dr. Ridenour has created a book for a much larger audience.

The history and growth of the mental health movement in this country is traced down through the past fifty years to the present, witnessing highlights of events, ideas, and people in mental health history.

Copies of the book are available in cloth edition from the Mental Health Materials Center, 104 East 25th Street, New York 10, New York at the following prices: 1-4 copies, $3.50 each, 5-24 copies, $2.63 each, and 25 and over, $2.34 each. Paper-bound editions are available only in lots of 50 or more at the following rates: 50 to 99 copies, $1.75 each; 100 to 249 copies, $1.50 each. Rates for larger quantities are available upon request.

New Film on PKU Added to Library

PKU—Preventable Mental Retardation, 15 minutes, color, 1961—The film describes the condition of phenylketonuria, or PKU, a metabolic deficiency in infants and young children which leads to eventual mental retardation if untreated. Success in preventing retardation through early diagnosis and careful diet therapy and the tragic results when PKU is too long undetected are dramatically shown in clinical film reports and observations by Richard Koch, M.D., of the University of Southern California School of Medicine and Los Angeles Children's Hospital. Stress on the importance of early routine testing with ferric chloride of all infants' urine is made, since this test for PKU usually becomes positive when the baby has reached the age of four to six weeks.

Suitable for medical, nursing, and public health groups, and for parents' groups when a resource person is present to answer questions. International Film Bureau, Inc.

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